NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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11:00 a.m. ET

Operator: Welcome to the conference. Please note today's call is being recorded. Please stand by.

Evan Williamson: Hello, everyone. Good morning and welcome to the Cost and Resource Use Measure Question-and-Answer Call. My name is Evan Williamson the Project Manager. I'm joined in the room today by Ann Phillips, Project Analyst. On the phone as well we have Ashlie Wilbon, Managing Director for Performance Measurement, and Taroon Amin Senior Director for Performance Measurement.

At this time, I would like to take a roll call of the committee members. I know this an optional Q&A call. We have another one scheduled on February 19th. So, I'm not going to run through the entire roster. But if you are committee member, if you could please identify yourself, we'll make sure that we write that down and make sure we know that you are on the call.

So, do we have any committee members on the call right now?

Carolyn Pare: Carolyn Pare.

Evan Williamson: Hi, Carolyn.

Carolyn Pare: Hi.

Mary Ann Clark: Clark.

Evan Williamson: Mary Ann?

Mary Ann Clark: Yes.

Evan Williamson: OK, great. I didn't hear first part of that. That's great. Welcome. Anybody else?

Mary Ann Clark: Thank you.

Andrea Gelzer: Andrea Gelzer.

Evan Williamson: Hi, Andrea.

Andrea Gelzer: Hi.

(Thomas Feng): Hi. This is (Thomas Feng) from (Merck).

Evan Williamson: Hi, (Tom). How you're doing?

(Thomas Feng): Good. How are you?

Evan Williamson: Good.

Andy Ryan: Hi, this is Andy Ryan.

Evan Williamson: Hi Andy. How you're doing?

Andy Ryan: Fine. Thanks.

Evan Williamson: Great. Do we have anybody else?

All right, great. Do we have any representatives of our measure developers on the line?

Nancy Kim: Hi, it's Nancy Kim from Yale CORE.

Evan Williamson: Hi, Nancy. How you're doing?

Nancy Kim: Fine, thank you.

Benjamin Hamlin: Hi, this is Ben Hamlin from NCQA.

Evan Williamson: Hi, Ben, welcome.

Benjamin Hamlin: Thank you.

Evan Williamson: Great. So, again, well really, the purpose of these calls is really to give the committee members an opportunity to ask questions of NQF staff about the review process of the measure developers about any questions that come into so far when reviewing the measure documents. They can ask questions of each other about the review process so far. So, again, this is really kind of a, just an opportunity to open it up where we want to provide that opportunity as you review these measures, to get all your questions answered and, you know, help to raise issues for the developers to address and (then move) into our in-person meeting in March.

So, at this point, I will open it up to the developers. We have screen sharing set, or opened up to the committee members, I'm sorry. We have screen sharing setups so we'll be able to pull up the relevant documents. From our site we have a review, you know, our measure evaluation criteria and then the actual specifications documents just in case we need to refer back anything. So, this time, we'll open it up for any questions from the committee.

OK. So, we're not hearing any questions so far. Let's see, let's think about what would be most helpful now.

Ashlie Wilbon: Hi. Hi, Evan. This is Ashlie.

Evan Williamson: Yes?

Ashlie Wilbon: I guess I would just ask the committee just, I guess for those that are on the call so far, has everyone been able to access the document on SharePoint OK? And also there was something, some additional materials that we provided that's somewhat new. It was a staff review of the measure where the staff went through and review the measure and provided kind of some summary, comments, and tried to point out some things and questions for the committee to focus on based on staff initial assessment of the measure.

So, to those that have had an opportunity to review the documents or maybe that document in particular, just any feedback you have on the utility of that whether or not that has helped your review of the measure or just in general kind of orienting yourself to the survey process which for those of you that have returned on the committee from last summit it's a little bit difference in the process we used to collect your initial evaluations of the measures. So, anything along those lines is definitely (fair game). And we're interested in hearing your input not only on the measures but kind of about the process where as you guys know, we're implementing a lot of process improvements. So, with input you have on, you know, how it's been so far would be useful as well.

Evan Williamson: Thanks a lot, Ashlie. So, up on the webinar now for screen sharing, I brought up the committee SharePoint page here so, and then we can walk through any of that if you have (any agreement) you want to comment on after (it's) brought up.

Andy Ryan: So, Evan, this is Andy Ryan. And would it be appropriate to ask kind of a question to the measure developer to maybe anticipate an issue that may arise in the actual review of process?

Evan Williamson: Absolutely. That's definitely in scope for this call.

Andy Ryan: OK. So, hi, I'm sorry I'm not sure if I got the name right for the Yale, the author who is on the call with the remission measures.

Evan Williamson: That's Nancy.

Andy Ryan: It's Nancy? But my question has to do with the validity of the heart failure measures. And, you know, there's been a lot that's been out in the literature about, you know, how valid these measures, the readmission is for the medical conditions. And I think, you know, the question of validity and getting the right yardstick to say, OK, this correlated with things that other measures of quality that we think are important. I mean it's kind of looking at the cup half empty or half full and people kind of disagree what the (inaudible). So, I'm just kind of curious what's the kind of general argument is going to be if

you're willing to share it about, you know, the why or what's the kind of assertion based on the evidence that this the readmission measures have sufficient validity in there, you know, (through bank QF) to these process.

Nancy Kim: Can anyone hear me? It's Nancy Kim.

Evan Williamson: We can hear you now.

Nancy Kim: Oh OK, good. I just want to make sure we're talking about the correct measure. I am the lead on the heart failure payments, episode of care payments. Is that the measure that you are asking about, Andy?

Andy Ryan: Yes.

Nancy Kim: And your question is how do payments correlate to quality?

Andy Ryan: Yes.

Nancy Kim: So, that's an excellent question. Both AMI and the heart failure payment measures were constructed to be aligned with our heart failure and AMI quality measures. In and of themselves, the payment measures are exactly that payment measures but they are meant to be paired with the quality measures to eliminate value. Does that answer your question?

Andy Ryan: And what – could you describe the state of the – you know, I haven't reviewed the materials (supposedly) but how – could you describe the analyses you've done that – we're you evaluating correlations between the payment measures and the other quality measures?

Nancy Kim: Sure. I mean the payment measure itself is just a payment measure. We have the supplementary analyses that are not part of the payment measure that look at how the payment measures correlate with quality specifically both the AMI 30-day mortality measure and the heart failure 30-day mortality measure (inaudible) (in the) AMI arena.

I know you're asking more about heart failure. And because it's a 30-day measure both for payments and for mortality, we don't find a terrifically high correlation between how hospitals appear on their 30-day, after (inaudible) of

their payment end of 30-day mortality measure. But that, I just want to remind the committee is just the payment piece of that.

Andy Ryan: Right.

Nancy Kim: This is not the value measure. This is the development of the payment methodology.

Andy Ryan: Right. And so, what about other broad measures of health care spending beyond, you know, a 30-day window and maybe different types of spending. What's kind of – what (has been) your analysis of the 30-day heart failure payment? You know, what are the other cost measures that correlate most closely with and might be less correlated with?

Nancy Kim: Are you asking how a 30-day heart failure measure compares to other measures?

Andy Ryan: Yes.

Nancy Kim: We have not looked at that specifically. I don't know if somebody from NQF wants to respond to that.

Evan Williamson: Ashlie or Taroon, would you want to respond to that?

Ashlie Wilbon: I'm not sure. This is Ashlie. I'm not sure exactly from the NQF perspective what there might be to add except that – and Andy was on a committee before, but I think the unique aspect of these measures kind of being linked to quality is something that linked to a quality measure that we can identify. It's something that's new and it might be a little challenging. But I guess the focus obviously of the measure evaluation it's going to be on the cost measure. But I would anticipate because that link has been explicitly stated, that that could be, as Andy is alluding to, an issue that the committee would want to kind of understand and learn more about particularly as it's maybe related to how validity would demonstrate in terms of, you know, correlations with other measures of quality. So, not sure if that answers the question or complicates things, but happy to expound more if needed.

Andy Ryan: Just this one question is that, has there been any analysis to (assess) the correlation between the cost in the 30-day window versus cost and other post-discharge windows?

Ashlie Wilbon: Not specifically in preparation for this. That is an evaluation that we have planned for what we call measure maintenance. And that's happening currently, but we haven't really planned, we have not done analyses for (inaudible).

Andy Ryan: OK. Thank you.

Male: (Inaudible).

Janis Orlowski: Hi, this is Janis Orlowski I have two questions.

Evan Williamson: Hi, Janis. Yes, go ahead.

Janis Orlowski: Hi, just a couple of things. One is I tried to speak via the web link and I wasn't able to – so, I don't know if that's supposed to be a capability or not. I also heard that you asked a question of will there any problems with the SharePoint and I would – my comment is that it was very easy to use, so I appreciate that.

As a new committee member, I might have some questions that you might have to help me with just to get rolling. But sticking with 2436, which is the 30-day episode of the care for heart failure, I have two concerns, one is how do you distinguish those hospitals or care events that are associated heading towards left ventricular assist device or transplant program where they may have significantly different research utilization for those patients as opposed to those that are in the hospital with the diagnosis of heart failure but have no intention to proceed to a program

Nancy Kim: Thank you for that question. It's Nancy Kim from Yale CORE. We exclude those who have heart transplant or LVAD under index submission or during their 30-day episode of care payment window.

Janis Orlowski: So, is that really enough because often people will come into the hospital with heart failure and will be worked up and placed under the transplant list but may not be transplanted for significant period of time, but may come back for further workup? So, are you really able to distinguish those individuals?

Nancy Kim: We haven't done more supplementary analyses to (view) the suggestion to identify those individuals' concerns. We have not done that, to answer your question directly. We do plan to exclude those with a history of LVAD or heart transplant. (Inaudible) …

Janis Orlowski: Right. But if they don't have a history, if it's a prospective plan procedure, I think that we have to be able to separate those folks out.

Nancy Kim: OK. I appreciate that comment. We haven't done that and I will also say that our heart transplant and LVAD exclusions were quite, quite small with 0.04 percent of our cohort for LVAD on the index with a 30-day window and 0.05 percent of our cohort for heart transplant, but I appreciate your comment.

Janis Orlowski: Yes. I think that certainly if someone is listed, are going to be listed for transplant that we would, that there's a mechanism to identify those individuals, if there is an anticipation of medication trial, then followed by a device, I don't know that you'd be able to identify them unless you look at subsequent admissions.

So, if you see someone who six months later or 12 months later has a device, I think that it affects their earlier resource utilization. So, I don't know if there's an opportunity to look backwards in that respect. Then that (serves) off the top of my head I could think of – try to think some other opportunities.

Nancy Kim: Yes. Again, I appreciate the comment because LVAD is being used more commonly as time goes on as you all know, but we are limited by our CMS claims data and because of the share volume, we really like to limit the amount of data that we had looked at for (inaudible).

Janis Orlowski: My other comment with 2436 is I believe that there is often confusion between heart failure and end-stage renal disease (would) fill it overload. And I believe that end-stage renal disease would fill it overload often either due to

misanalysis or non-compliance with fluid restrictions. I see those often getting (used) in the hospital. And so, for example, to look at the CMS bundle on heart failure, if you go through that, it can often be (tainted), so to speak, with ESRD patients with fluid overload because the coding doesn't distinguish between the two of them. And I think that there are two very different events that occur. And into look at left ventricular function or to do the other parameters with ESRD and fluid overload is probably wrong from a medical care point of view. So, I look at them as two different types of diagnoses, and I would actually exclude ESRD with fluid overload unless the physician clearly believes that there's an element of heart failure with that.

Nancy Kim: Hi, it's Nancy Kim from Yale CORE. Thanks for that comment. (That's not apparently) explicit exclusion we identify our cohort using the ICD-9 codes that I'm sure you read in our material but thanks for that thought. (Then the next) …

Evan Williamson: Thanks a lot, Janis – sorry, I just wanted to comment on the webinar capabilities. So, the webinar, we do streaming webinar but it doesn't allow interacting with the …

Janis Orlowski: It doesn't. OK, thanks.

Evan Williamson: … (inaudible). So, the streaming is only for people who want to listen in the webinar but not be available to speak, so just …

Janis Orlowski: Perfect.

Evan Williamson: … for clarification, yes.

Janis Orlowski: Thanks for that clarification. And right now, what I'm seeing on the webinar is the agenda and not the SharePoint, although you had mentioned that you're going to put the SharePoint up.

Evan Williamson: Let me go back to that exact – In the room here, I'm sharing the brief measure information for 2436 and I guess let me make sure that ...

Janis Orlowski: And I was going saying and I'm not seeing it, maybe others are on the web link but for your information.

(Crosstalk)

Female: You may want to try refreshing your browser.

Janis Orlowski: Will do.

Female: And that may help update you.

Janis Orlowski: So, my next question is with 1558. And I have three questions with that. My first is as we take a look at the procedure codes that are included, there is our procedure code for carotid endarterectomy, and I am, but there are not other peripheral vascular disease intervention codes included. And I was wondering why with coronary artery disease there would be a carotid code included but not the other peripheral disease codes.

Benjamin Hamlin: So, this is Ben from NCQA. I'm not exactly sure what you're talking about in the inclusion criteria. There are other in the (value set) list that was provided. There are other the peripheral vascular disease codes that are included. The carotid, I think, is particularly called out because it's one of the frequency of service categories for the measures. So, I'm not sure which section of the measure you're looking in because we separate that under the specific frequency of service per member per year for each plan.

Janis Orlowski: Let me just look at this and see if I can bring you to that. So, your intention with 1558 is to measure cardiovascular disease including all of the peripheral vascular interventions?

Benjamin Hamlin: Yes. Pretty much anyone who meets our definition for ischemic vascular disease is included in the measure, and that's the inclusion. And then what we do is we look at the relative resource use for that entire population over the entire year without trying to associate specific services, you know, to cardiovascular disease. Specifically, we just look at, you know, again, any identified population.

As part of that though, we do break out certain procedures, (competent) more procedures in this population. And the carotid is one of them, CABG is another, and (the pills) are reported (at) a per member per year frequency of service (inaudible) wrong side all of the resource information so that the carotid is included and (priced in the resource each side) and in the standard pricing tables but it's also included as a frequency of service number.

Janis Orlowski: I see. So, you are just looking in that, the carotid particularly, but you don't mean to exclude the other vascular procedure?

Benjamin Hamlin: Right. They're definitely included …

Janis Orlowski: OK.

Benjamin Hamlin: … in the identification of population. And, again, you know, some of them are also included as under the (frequency) – CABG, you know, cardiac C.T., carotid endarterectomy, you know, a number of those, (that aren't in the frequency) categories as well. So, there's a lot of different sub-components to the measure, so I just wanted to make sure you were looking the right (part) or I was telling you the right answer to the right part.

Janis Orlowski: I think that I was looking at the summary which just called out the carotid endarterectomy but I do see it now.

Benjamin Hamlin: OK.

Janis Orlowski: And did you also include …

Benjamin Hamlin: (Inaudible) include – I'm sorry, go ahead.

Janis Orlowski: But did you also – besides peripheral vascular, do you also include renal artery procedures?

Benjamin Hamlin: The procedures, I'm not sure, but (absolutely it should have been called the value hit list). Most of it, there are some renal diagnosis. But the procedures, I am not sure those are included in the identification. I'm trying to (inaudible) (value set list here).

(John Albert): This is (John Albert). I just like to do a follow-up question (to move to this).

Benjamin Hamlin: Sure. You can (inaudible). I'll keep looking.

Evan Williamson: (John), go ahead.

(John Albert): So, you're triggering based on procedures for cerebrovascular disease not just cardiovascular since you're looking at carotids for 1558?

Benjamin Hamlin: To get in to the measure, yes, there are a series of diagnoses, sort of under the ischemic vascular disease umbrella that will get you in either procedures, if you have an AMI or CABG or some PCI procedure and that you're part of the measurement (year) or diagnosis of IVD, (and all sorts of) a list of values that are included under that, that will get you into the eligible population. We don't …

(John Albert): So, (not digging) to your ICD-9. Do you use carotid endarterectomy as a trigger? Do you use stroke that's medically treated or cerebrovascular event that's non-treated with the carotid endarterectomy as a trigger as well? Are you just looking for treatments that are heading to endarterectomy?

Benjamin Hamlin: Just (bringing) in those who have a diagnosis. And so, as you know, some sort of ischemic diagnoses are the eligible population. We don't generally include procedures as an identification. Like I said in this case, you know, certain PCI procedures are included as long as the patient (had them prior) because we're using our standard definition for IVD, which is across the number of different measures. It's (inaudible) the definition (because of) cardiovascular conditions that we use and it's because of the way (clients work for that), (who's going to have to go that) to your definition.

(John Albert): Can I ask one more procedural question while I have (the floor), probably more for NQF?

Benjamin Hamlin: Sure.

(John Albert): 1558 is a more, I thought it was relatively mature measure for something that's been up there. The point for this re-review is …

Evan Williamson: Ah, yes, this is Evan. (Our measures) go through we call measure maintenance. So, after a measure has been endorsed within three years, we bring them to a maintenance process where they go on into the review again.

(John Albert): So, the point is not expanding the scope of the measure or changing the measure, is it's just a routine re-review of 1558?

Evan Williamson: Yes. I mean we do have some additional information about the measuring use on our forms for our maintenance measures but this isn't, you know, a material change to the measure or something of that nature. It's more aligned. This is our standard process for reviewing measures in our portfolio.

(John Albert): Thank you.

Joseph Stephansky: Evan, following up on that and this is Joseph Stephansky, I'm sorry for joining late.

Evan Williamson: Oh, no problem

Joseph Stephansky: In a three-year period, there often can be some tweaks to a measure. And so, I guess what I'm interested in when we see a measure coming up for re-endorsement process, some summary of any changes in the measure itself even if they're minor and any changes in the science underlying the measure that might be pertinent.

Evan Williamson: Yes. Let me actually – Ashlie or Taroon, do you want to expand on our maintenance process? You know, I'm trying to pull up some information here but what we do ask questions about the measuring use in the maintenance process. Let me (inaudible) …

Ashlie Wilbon: Yes. So, this is Ashlie. This is Ashlie, Joe. I think that's a really good point. I think our process for collecting information on maintenance measures has been pretty standard and we're always looking for ways to improve. But I think you bring up a good point as we have standing committees that have reviewed measures like the state measure, you know, before in the past that might be useful to have a way of kind of collecting the information about the

measure of specifically what's changed or what's different since the last submission in a more succinct way.

So, that's a point very well-taken. And I would probably just ask Ben if there's, you know, if he's able to kind of maybe point out a few things if there's anything that has changed in the study that might be valuable for the committee to know.

Benjamin Hamlin: Yes, I'd be happy to. So, I want to answer the older questions first in the – if you're interested in the list of IVD diagnoses that we use for the eligible population, they can be found starting on page 91 of the clinical logic PDF that was included in the measure form.

Ashlie Wilbon: Right. Thank you.

Benjamin Hamlin: So, they're sort of long list ICD-9 primarily. We have now posted also ICD-10 in (corollary), and I did not include those because those are only being initiated this year upcoming. So, that was one of the changes that we've done. We've mapped everything in all of our measures from ICD-9 to ICD-10.

For our measures as well as far as our standard pricing tables, those get updated every three years. However, every year, we do apply, you know, a minor cost adjustment (that's facing the) same as Medicare (data) so we try and, you know, keep the standard prices that we used for our (research, use) relatively up to date.

The other thing that we did actually add this year were two service categories. So, one of the things that we cast before we included services in our relative resources measures as we look for, you know, reliability and consistency in the coding of the claims to ensure that if we're including services in our standard pricing table, that they're as accurate as possible, you know, given the nature of the administrative claims.

And we were able to add diagnostic laboratory and diagnostic imaging as to new service categories in the relative resources measures. So, the resources used under those specific categories are now included as separate, reported out for our research use. So, that was the biggest change. Pretty much everything

else – the risk adjustment is still the same apart from sort of the coding updates over the last couple of years, those have remained fairly consistent.

Everything we did do was we actually removed for this measure and for the diabetes measure the mandatory ESRD exclusion. So, previously, we had anyone with active cancer, HIV, ESRD more automatically excluded from the measure because we had concerns about the cost, you know, imagine those patients costs a lot and we were afraid that certain plans with many ESRD patients would be capping out the resources used.

So, we went back in after a couple years of data collection, looked at that specifically to see if that was the case because of concerns from the initial review at NQF saying, you know, ESRD is really kind of a critical component of cardiovascular conditions and diabetes. And we found that it didn't really (skew) the results so much that would – so we decided to remove that as a mandatory exclusion. So, active cancer and HIV are still automatic exclusions from the measure category because the costs associated with treating those patients, but ESRD has now been removed. So, ESRD patients with ESRD categories are now included in the measure of resources for these patients.

So, those were the three major changes we had since the initial review.

Joseph Stephansky: Good. That helps in your risk adjustment over the (time course). Or have you learned anything about relative risk adjustment with wider use of 1558?

Benjamin Hamlin: Well, we've – you know, so we use a CMS-HCC risk adjustment approach, and we do an annual analysis looking at the correlations between the service categories in a specific risk cohorts, you know, for the, you know, how is this reported out, I mean sort of looked for trends in those correlations between services and the patient types in the risk adjustment model.

Because we only get aggregate data at NCQA from (Edith's) reporting, it's a lot of aggregate data but it's not patient level. We don't go back in and retest the risk adjustment specifically for each of these cohorts. You know, we rely on the HCC to be, you know, CMS to sort of keep the model of the (date), if

you will. You know, we usually tested it for appropriateness for these measures, but we've not done any specific testing on the risk (adjustments).

Joseph Stephansky: Thanks.

Ashlie, this is Joe Stephansky again with a ...

Ashlie Wilbon: Hi.

Joseph Stephansky: Yes, this is a question that you may have already covered because I joined late. As I look at the Yale measures, the CMS measures for CHF and AMI, and the idea of linking together both this particular resource use measure with the mortality and the readmissions measure and I assume we're going to see the pneumonia side of this soon probably in front of this committee on the (research side).

We've already had the technical experts looked at the clinical side in both the mortality and the readmissions measure, and now we're kind of looking at it again. I guess the thing that worries me a little bit is if we find or as a group or a substantial portion of the group finds a problem with the clinical logic, we really are talking about having to go back and review those other associated measures to make it useful for what we're going to want in terms of what's coming up next linking quality and cost.

Ashlie Wilbon: Yes.

Joseph Stephansky: So how – this is kind of a – this is really a funny evaluation and a way considering we're not just (protecting) this measure but we have ripple effects.

Ashlie Wilbon: Yes. I mean I think that's a very good point. And we'll actually be having a discussion with the committee at the in-person meeting something to this effect as we kind of move towards the standing committee somewhat taking ownership over a portfolio of measures and seeing how getting an idea of how measures are related to one another in the cost area and where that responsibilities should lie in terms of reviewing and the impact that it may have by having measures kind of parse out by, you know, under review from different groups.

So, we'll talk a little bit about that. In terms of, kind of the process that we have right now, obviously, we kind of have to go forward with where we are in terms of reviewing what we have in front of us, taking the input and providing that feedback back to the developers. We'll have to kind of see how that goes. It's hard to say right now how that might impact, but I think it's a very good point. And it will be definitely be something that's on our radar as we move forward.

Joseph Stephansky: I have a tendency to – and this is a personal bias – to probably look at the measure details with a little less critical eye because I want to see that the multiple measures work together. That may not be a good bias to have in this case. I don't know. But I mean I recognize it but I'm not sure exactly how it's going to affect how I look at this.

Ashlie Wilbon: Yes and I think it will balance that. We did have a clinical group look at the measures and obviously there are a lot of clinicians on this committee, this standing committee as well. So, I think, you know, the purpose of having a lot of people with different backgrounds and different expertise is that, you know, people will focus on different parts of the measures because of their expertise and for various reasons.

So, I think that will all balance itself out. We'll kind of have to see where we land when the group convenes to see what concerns they're maybe. Our (tests) that we convened for the review of these measures, last week, I believe …

Joseph Stephansky: Yes.

Ashlie Wilbon: And so, we'll be compiling a summary of those, of that input this week and hopefully distributing that to you by the end of the week. So, you'll have an idea of kind of where they landed on something. And, again, there are several clinicians on this committee as well. So, that should give you a good idea of what issues there are maybe (to discuss).

Joseph Stephansky: Well, I did listen in on the TEP call.

Ashlie Wilbon: Oh, OK, great. Great.

Joseph Stephansky: And then that was pretty straightforward. And, you know, I was concerned about, as I said before, changes in science that might have showed up that I needed to know about, but that was pretty straightforward, I think.

Ashlie Wilbon: OK, great.

Andy Ryan: Ashlie, this is Andy. (On the same point), you know, that was 2158 is a payment standardized Medicare spending for beneficiary. And, you know, there is a different developer on that. And, you know, these AMI and CHF measures are basically a subset of that larger measure. And so, you know, did NQF give specific instructions with respect to harmonizing with that measure? Or is this, because – or, you know, how – I'm just kind of wondering what instructions trying to anticipate what this is going to look like to the committee given that there's already, you know, a larger measure that in some sense already subsumes through these measures that we're going to consider.

Ashlie Wilbon: Yes, that's a great question. We did have some calls early on with the developers. This was back actually before the (phase) had just ended; so, like about a year ago kind of about how all of these measures (put) together. And I do think that although we didn't focus, I think, the assumption – and I'll kind of throw this out to Taroon if he is able to comment on, the assumption was based on our conversations with them that they were built to already kind of – they already built in to kind of be harmonized, that was already kind of built in to their development process. Although, I will, with the developers on the call, I probably like to go back (to them) just to confirm. But I don't think it will add concern to harmonization within this group of measures as we were kind of with other measures from different, when I say different developers, I say, meaning outside of CMS, (they're not a facility), they're sub-contractors but outside of CMS.

So, I think, again, just in case that was confusing, I think we were less concerned with the harmonization within this group of measures, this related group of measures from CMS as we were with other measures. And my understanding was that they were, as they were built, they were, that

harmonization was kind of inherent in the way they're conceptualized, but I can obviously (send that over to you). The developers have some insight on that to offer.

Nancy Kim: Hi. Can you hear me? It's Nancy Kim.

Ashlie Wilbon: Yes.

Nancy Kim: Am I on or (good)?

Evan Williamson: Yes, we can hear you.

Nancy Kim: OK, good. Thanks. I think Ashlie is right, we had a number of calls over the development phase, over the last year, year and a half. And I think we did land exactly were she said, we harmonized where we could. But because ours is condition-specific as you pointed out, meant to be paired with the AMI and heart failure (for today), (risk) (inaudible) mortality rates that we served (for slightly) different purpose and that there is benefit to having both measures.

Ashlie Wilbon: And that's definitely certainly something we can have a larger depression about with the committee when they, when you guys come in person to see how they all fit together.

Joseph Stephansky: Yes. This is Joe Stephansky again. Yes, I think that actually that they're lining up quite nicely. I am a little bit concerned – well, (partly) what I see is, you know, NQF staff, you guys are already running at red line and let me guess, the Yale developers are already running at red line and there's not lot of resources or time left to clean everything up. And we have to have a little bit of tolerance and help each other out on this.

I did notice a few place just for example in the CMS Yale documents where there were some probably in contradictions in and they were just simply errors in areas where it looked like the different developers, say from the readmissions measure to the cost side of it, didn't really understand each other's measures that well phrases like that the readmission measure was based on admission date. Things like that tells me that these groups may not

be sitting down together as much as might be desired. But, overall, I think it's gone pretty well.

Evan Williamson: Great. Thanks, Joe. Do we have any other questions?

Joseph Stephansky: All right, Joe again, just thinking ahead as to where we're going to run into some potential problems, not that the measures need to be changed at this point but we got to think about it because we're dealing with hospital stays that are often very short which means we are dealing now with how lack audits may affect an inpatient status, the audit itself made to roll back into the outpatient side. And I'm not sure how those are being picked up because they can affect the cost measure in quite a few ways. And the other thing we've got to think about is what's going on with observation status. And (there's two midnight rule) that eventually will get implemented here, which I think is going to introduce some administrative noise to these measures.

(John Albert): (John Albert) here. So, CMS, based on some pretty (stiff) pushback about the two midnight system, (I know it's going to back off that at present) and they're sort of reassessing how they're going to define an inpatient admission. So, that goes the whole point. There's like …

Joseph Stephansky: Yes.

(John Albert): … no career definition and hospitals had to work from CMS with regards to what inpatient versus outpatients is. At the (rock), we use one definition. Apparently CMS isn't quite happy with that definition. But my knowledge it's kind of still up in the air.

Joseph Stephansky: I think there's been a six-month postponement in enforcement. But one way or another that the whole issue between inpatient and observation status again could – whatever happens with these rules – could introduce administrative (noise). It doesn't have anything to with the clinical treatment of patients.

(John Albert): I completely agree with that. But in my experience, I'm not good at predicting what CMS does. So, I might have to wait and kind of see how CMS responds to this.

Joseph Stephansky: Yes.

(John Albert): But I hear your point and I think it's extremely valid because that may (pull a monkey wrench) into a number of these measures. It's almost like we had to kind of wait and see what CMS does.

Joseph Stephansky: Yes.

(John Albert): Perhaps build in a bit of flexibility to allow for anticipated changes, but otherwise it's kind of (holding) …

Joseph Stephansky: I think because we're …

Nancy Kim: I do think that the heart failure one in particular could be dramatically affected because someone could come in for pulmonary edema, be in the ICU, be (diurist) over a day, may or may not be intubated and be out within 48 hours. And if all of those go to midnight rule, it would dramatically change the payment associated with that kind of an episode. So, I think what you're bringing up is very timely.

Joseph Stephansky: I don't think we need to worry about making any adjustments in the measures now. But particularly since we're heading for standing committees looking over these areas, we just need to keep this stuff in the background and watch for impacts.

Evan Williamson: Thanks a lot, Joe. We're definitely taking that down. We'll, we would set aside some time, again during our agenda, during our in-person meeting to really kind of go over the scope of the standing committee and really what kind of issues we're going to be looking at on, you know, to have a long-term basis. So, I think that point is very well taken. Thank you.

Joseph Stephansky: Yes.

Evan Williamson: Do we have any further questions for each other, for the developers, for us?

Great. OK, well at this time we want to open it up for public and member comments. I know we have some other people besides committee members

and developers on the call, so we'll open it up. Operator, could you please open it up? Operator?

Operator: At this time, if you would like to ask a question, please press star one on your telephone keypad.

And there are no questions at this time.

Evan Williamson: Great. Thank you very much. Well, at this time, we're going in our next steps. We have another Q&A call scheduled for February 19th, and this is one where we'll have distributed the TEP evaluation summary to you prior to that call, and we've asked members of the TEP to be available on that call to answer questions about their evaluation. So, again, we will have a (further) opportunities to ask questions about the (medical) specifications, about the review process evaluation, and then again about the TEP evaluation.

So, that's the next step. We have our in-person meeting, March 4th and 5th, here in Washington D. C. If you've not received the logistics already, you should be receiving them shortly for your – reserve your hotel room and to book your travel. We look forward to seeing you all out here. We think this is going to be a great meeting. We're looking forward to kind of the, again as we mentioned earlier, the scope of the standing committee, this is new for us and we're really excited about the opportunity (that's raised) us to really have ownership over a portfolio of measures.

And, again, I want to think the developers for being present on this call and graciously answering questions, and for the committee members who were able to ask questions today, we thank you very much. So, this will conclude the call and thanks a lot.

Female: Thank you.

Female: Thank you.

END